Washington State Department of Social & Health Services

HEALTHY KIDS
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

SECTION I. PATIENT INFORMATION

1. PATIENT'S NAME	2. SEX ☐ Male ☐ Female	3. PATIENT IDENTIFICATION CODE (PIC)	4. BIRTH DATE

5. RACE	6. PARENT'S/GUARDIAN'S NAME	7. RELATIONSHIP TO PATIENT	8. TELEPHONE NUMBER

9. STREET ADDRESS	CITY	STATE	ZIP CODE

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. PRIMARY CARE PROVIDER'S NAME	2. TELEPHONE NUMBER	3. DATE OF SCREENING

4. STREET ADDRESS	CITY	STATE	ZIP CODE

5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING	6. LIST PHYSICAL CAUSES THAT WERE RULED OUT

7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED

8. REFERRAL TYPE	9. REFERRED TO:
☐ Regular ☐ Urgent	☐ Mental Health Assessor ☐ Substance Abuse Assessor ☐ Regional Support Network

10. REASON FOR REFERRAL

11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE	DATE

SECTION III. PATIENT INTERPRETATION CERTIFICATION

I certify that the above referral was explained to _____
PATIENT OR PARENT/GUARDIAN

in _____ and executed in my presence.
LANGUAGE

WITNESS/INTERPRETER'S SIGNATURE	DATE

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. ASSESSMENT RECEIVED

☐ Mental health ☐ None; explain:
☐ Substance abuse

2. INITIAL TREATMENT PLAN

3. EXPLAIN WHY IF NO SERVICES ARE NEEDED

4. ASSESSOR'S NAME	DATE	5. TELEPHONE NUMBER

DSHS 01-192 (REV. 07/1994)

See reverse for instructions.

PRIMARY CARE PROVIDER

Washington State Department of Social & Health Services

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5. RACE	6. PARENT'S/GUARDIAN'S NAME	7. RELATIONSHIP TO PATIENT	8. TELEPHONE NUMBER

9. STREET ADDRESS	CITY	STATE	ZIP CODE

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. PRIMARY CARE PROVIDER'S NAME	2. TELEPHONE NUMBER	3. DATE OF SCREENING

4. STREET ADDRESS	CITY	STATE	ZIP CODE

5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING	6. LIST PHYSICAL CAUSES THAT WERE RULED OUT

7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED

8. REFERRAL TYPE	9. REFERRED TO:
☐ Regular ☐ Urgent	☐ Mental Health Assessor ☐ Substance Abuse Assessor ☐ Regional Support Network

10. REASON FOR REFERRAL

11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE	DATE

SECTION III. PATIENT INTERPRETATION CERTIFICATION

I certify that the above referral was explained to _____
PATIENT OR PARENT/GUARDIAN

in _____ and executed in my presence.
LANGUAGE

WITNESS/INTERPRETER'S SIGNATURE	DATE

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. ASSESSMENT RECEIVED
☐ Mental health ☐ None; explain:
☐ Substance abuse

2. INITIAL TREATMENT PLAN

3. EXPLAIN WHY IF NO SERVICES ARE NEEDED

4. ASSESSOR'S NAME	DATE	5. TELEPHONE NUMBER

See reverse for instructions.

RSN

Washington State Department of Social & Health Services

HEALTHY KIDS
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REFERRAL FOR MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT

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5. RACE	6. PARENT'S/GUARDIAN'S NAME	7. RELATIONSHIP TO PATIENT	8. TELEPHONE NUMBER

9. STREET ADDRESS	CITY	STATE	ZIP CODE

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. PRIMARY CARE PROVIDER'S NAME	2. TELEPHONE NUMBER	3. DATE OF SCREENING

4. STREET ADDRESS	CITY	STATE	ZIP CODE

5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING	6. LIST PHYSICAL CAUSES THAT WERE RULED OUT

7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED

8. REFERRAL TYPE	9. REFERRED TO:
☐ Regular ☐ Urgent	☐ Mental Health Assessor ☐ Substance Abuse Assessor ☐ Regional Support Network

10. REASON FOR REFERRAL

11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE	DATE

SECTION III. PATIENT INTERPRETATION CERTIFICATION

I certify that the above referral was explained to _____
PATIENT OR PARENT/GUARDIAN

in _____ and executed in my presence.
LANGUAGE

WITNESS/INTERPRETER'S SIGNATURE	DATE

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. ASSESSMENT RECEIVED

☐ Mental health ☐ None; explain:
☐ Substance abuse

2. INITIAL TREATMENT PLAN

3. EXPLAIN WHY IF NO SERVICES ARE NEEDED

4. ASSESSOR'S NAME	DATE	5. TELEPHONE NUMBER

DSHS 01-192 (REV. 07/1994)

See reverse for instructions.

MENTAL HEALTH PROVIDER

Washington State Department of Social & Health Services

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SECTION I. PATIENT INFORMATION

1. PATIENT'S NAME	2. SEX ☐ Male ☐ Female	3. PATIENT IDENTIFICATION CODE (PIC)	4. BIRTH DATE

5. RACE	6. PARENT'S/GUARDIAN'S NAME	7. RELATIONSHIP TO PATIENT	8. TELEPHONE NUMBER

9. STREET ADDRESS	CITY	STATE	ZIP CODE

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. PRIMARY CARE PROVIDER'S NAME	2. TELEPHONE NUMBER	3. DATE OF SCREENING

4. STREET ADDRESS	CITY	STATE	ZIP CODE

5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING	6. LIST PHYSICAL CAUSES THAT WERE RULED OUT

7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED

8. REFERRAL TYPE	9. REFERRED TO:
☐ Regular ☐ Urgent	☐ Mental Health Assessor ☐ Substance Abuse Assessor ☐ Regional Support Network

10. REASON FOR REFERRAL

11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE	DATE

SECTION III. PATIENT INTERPRETATION CERTIFICATION

I certify that the above referral was explained to _____
PATIENT OR PARENT/GUARDIAN

in _____ and executed in my presence.
LANGUAGE

WITNESS/INTERPRETER'S SIGNATURE	DATE

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. ASSESSMENT RECEIVED

☐ Mental health ☐ None; explain:
☐ Substance abuse

2. INITIAL TREATMENT PLAN

3. EXPLAIN WHY IF NO SERVICES ARE NEEDED

4. ASSESSOR'S NAME	DATE	5. TELEPHONE NUMBER

DSHS 01-192 (REV. 07/1994)

See reverse for instructions.

ALCOHOL/SUBSTANCE ABUSE PROVIDER

INSTRUCTIONS

SECTION I. PATIENT INFORMATION

1. PATIENT'S NAME: The name of the patient being screened.
2. SEX: The sex of the patient being screened.
3. PATIENT IDENTIFICATION CODE (PIC): The state-assigned PIC number printed on the medical coupon.
4. BIRTH DATE: The birth date (month/day/year) of the patient being screened.
5. RACE: The patient's race.
6. PARENT'S/GUARDIAN'S NAME: The name of the patient's parent or legal guardian, if the patient is under 18 years of age.
7. RELATIONSHIP TO PATIENT: Mother, father, grandmother, legal guardian, etc.
8. TELEPHONE NUMBER: The telephone number of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.
9. STREET ADDRESS, CITY, STATE, AND ZIP CODE: The full address of the patient, or parent/guardian if the patient is not the responsible party for authorizing the mental health and/or drug/alcohol referral and exchange of medical information.

SECTION II. PRIMARY CARE PROVIDER INFORMATION

1. PRIMARY CARE PROVIDER'S NAME: The name of the primary care provider.
2. TELEPHONE NUMBER: The telephone number of the primary care provider.
3. DATE OF SCREENING: The date (month/day/year) the Healthy Kids/EPSDT screen was done.
4. STREET ADDRESS, CITY, STATE, AND ZIP CODE: The full address of the primary care provider.
5. LIST THE MEDICATION(S) THE PATIENT IS CURRENTLY TAKING: List the medication you are aware that the patient is taking, including prescription, over-the-counter, and illegal drugs.
6. LIST PHYSICAL CAUSES THAT WERE RULED OUT: List the physical causes that were ruled out that could cause or aggravate the mental health and/or drug/alcohol symptoms that are being exhibited or suspected.
7. DESCRIBE PREVIOUS MENTAL HEALTH/SUBSTANCE ABUSE SERVICES RECEIVED: Describe any known previous mental health/substance abuse services that the patient has already received.
8. REFERRAL TYPE: Indicate whether this is a regular or urgent referral.
   REGULAR REFERRAL - A regular referral is indicated if, in your professional **judgment**, behaviors are present that need assessing such as: alcohol/substance abuse; family conflict; troubled peer relationships; school failure; somatic symptoms, abnormal behaviors, feelings, or thoughts; growth and development deficits; or social situation problems.
   URGENT REFERRAL - An urgent referral may be indicated if any of the following behaviors are present: victimization (untreated behaviors still evident); witness to death/substantial physical violence; at imminent risk of placement in restrictive setting; delusional, out of touch with reality; self-destructive behavior; destroying property; torturing animals; fire setting; sexually acting out; and suicidal behavior/ideation. Please contact the mental health provider, alcohol/substance abuse provider, or crisis response services immediately as appropriate.
9. REFERRED TO: Indicate where referred - mental health assessor, substance abuse assessor, and/or Regional Support Network.
10. REASON FOR REFERRAL: Describe the reason this patient is being referred for a mental health or alcohol/substance abuse assessment.
11. PHYSICIAN'S/PHYSICAL EXAMINER'S SIGNATURE: The signature of the medical provider performing the Healthy Kids/EPSDT medical screen. This may be a physician, Advance Registered Nurse Practitioner, or Physician's Assistant.

SECTION III. PATIENT INTERPRETATION CERTIFICATION

The language interpreter that explained this form and its' purpose to the patient or parent/guardian should fill in the patient or parent/guardian's name and in what language. This should be certified by the signature of the interpreter, and should be dated (month/day/year).

SECTION IV. COMPLETED BY THE ASSESSOR AND RETURNED TO THE HEALTHY KIDS PRIMARY CARE PROVIDER LISTED ABOVE

1. ASSESSMENT RECEIVED: Indicate if a mental health or substance abuse assessment or no assessment was received by the patient. If no assessment was received, explain why.
2. INITIAL TREATMENT PLAN: Summarize the initial treatment plan of mental health and/or alcohol/substance abuse services you recommend the patient should receive.
3. EXPLAIN WHY IF NO SERVICES FOR THE PATIENT ARE NEEDED: If no mental health and/or alcohol/substance abuse services are recommended, explain why.
4. ASSESSOR'S NAME, DATE: Sign the mental health or alcohol/substance assessor's name and date of the assessment.
5. TELEPHONE NUMBER: The telephone number of the mental health or alcohol/substance abuse assessor.